REQUIREMENTS FOR THE INITIATION, COMPLETION, REVIEW, AND RETENTION OF PATIENT CARE RECORDS

PURPOSE

To delineate requirements within the EMS Region regarding the initiation, completion, review, and retention of EMT-P and EMT-I patient care record forms.

AUTHORITY

Title 22, California Administrative Code, Sections 1000168(6) (A-D) and 100085(6) (f)

INITIATION OF PATIENT CARE RECORDS (narrative patient care record and run report data sheet)

The patient care record form in the EMS region shall be comprised of the narrative patient care record form (EMS Run Report Form O1A or O1B) and a Run Report Data Sheet (Scantron form/F1612). They will be initiated every time a Paramedic makes a patient response to include "walk-in" patients. The narrative O1B form shall be initiated when an EMT-1A responds. The term "patient response" as used herein refers to all incidents in which an EMS unit is dispatched by an EMS service provider, where the outcome of the call results in patient assessment with service or treatment by the EMS provider.

In situations where more than one patient is encountered at the scene of an incident, one set of patient care record forms shall be initiated for each patient

In the event that two EMS provider agencies arrive on scene at an incident, each EMS attendant who has actual contact with a patient is responsible for completing a set of EMS patient care records. Each set of patient care records should contain an incident number and patient identification information and record those assessments, services, or treatments delivered by the EMS attendant(s) completing that form. Thus, a patient receiving initial BLS level service followed by ALS treatment by another provider agency would have two sets of EMS forms

The attendant providing patient care on the EMS unit is responsible for initiation of patient care records as stated above. As attendants within the EMS region are employed by EMS service provider agencies, additional responsibility for initiation of patient care records lies with the EMS provider agency.

RESPONSIBILITIES FOR RECORD COMPLETION

Each set of EMS patient care record forms shall be completed as specified in the 'EMS Run Report Form Completion Instructions", which serves as an extension to this policy. The attendant providing patient care on the EMS unit is responsible for proper completion of patient care records. Additional responsibility for accurate and thorough completion of patient care records lies with the EMS provider agency.

The EMS copies of each completed patient care record form shall be delivered to EMS within thirty (30) days following the end of the month in which the form was initiated. Responsibility for timely submission of these forms lies with the EMS service provider agency.

Attendants who fail to thoroughly complete patient care records according to this policy will be given an opportunity to

correct errors and/or omissions, following EMS review of the form as initially submitted.

In the event that addition(s) are required to a narrative patient care record form after submission of that form to the receiving hospital, a separate, new narrative patient care record form must be completed in full with one copy forwarded to the receiving hospital and one copy to EMS. Correction(s) to a Scantron form are to be made on the original Data Sheet whenever possible, and corrected Data Sheets sent to EMS in batches clearly marked as "corrections".

RESPONSIBILITIES FOR RECORD RETENTION

A. REQUIREMENTS

1. All records related to either suspected or pending litigation shall be held for an indefinite period of time.
2. The patient care records of all patients other than unemancipated minors shall be retained by the respective agencies for a minimum of seven (7) years.
3. The records of unemancipated minors shall be kept for at least one (1) year after such minors have reached the age of 18, but in no event less than seven (7) years following the provision of service to the minor.
4. All receiving hospital copies of the patient care record form shall accompany the patient to the receiving hospital and be retained by the receiving hospital for a minimum of one (1) year in the patient's medical record
5. The EMS service provider agency shall be responsible for retention of the provider copy of the patient care record form.

B. TYPES OF RECORDS FOR RETENTION

1. The Base Hospital information form for each Base Hospital advanced life support radio contact
2. Labeled tapes (not transcriptions) of communications between advanced life support personnel and the Base Hospital physician and/or MICN
3. Chronological log of each Base Hospital advanced life support radio contact
4. Patient care records (Form O1A and O1B)

C. RESPONSIBILITIES FOR RECORD REVIEW AND EVALUATION

Designated EMS staff shall be responsible for reviewing all completed patient care record forms submitted to EMS. Such review shall include, but not be limited to, procedures to determine the completeness of forms, methods to collect data recorded on the EMS copies of forms, and processing to produce statistical and quality assurance summary reports.

Evaluation of statistical summary reports shall be the responsibility of the EMS Agency Administrator. Evaluation of medical quality assurance summary reports shall be the responsibility of the EMS Medical Director. Copies of statistical summary and QA summary reports will be provided to provider agencies upon request